

Background: NICE recommends that patients undergoing endoscopy should cease treatment with a PPI or H2 receptor antagonist for a minimum of 2 weeks prior to endoscopy to prevent false negative tests.

Aim: To determine the extent to which these NICE guidelines are being followed in our Trust.

Method: This study analysed data obtained from questionnaires filled in by endoscopists at a district general hospital between October, 2010 and January, 2011.

Results: 67 questionnaire's were analysed. Median patient age was 80 years (male 48%, female 46%). Of the referrals analysed 62.7% were requested as a 2 week wait[s1] . Of this 2 week wait group, over 4 in 10 patients had been taking a PPI at referral. 24% of those patients on a PPI did not stop their PPI 2 weeks before endoscopy (of this group, a third were not verbally advised to stop PPI prior to endoscopy and 46% received the endoscopy information leaflet less than 2 weeks before endoscopy)

Conclusions: Lack of patient information may lead to the need for repeat procedures and potentially false negative endoscopies. This study highlights the importance of giving information leaflets during the consultation and verbally reinforcing the information.

0073: COMPLICATIONS OF LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING (LAGB) PERFORMED BY ONE SURGEON OVER A 10-YEAR PERIOD

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Background: Between November 2001 and September 2011, 1100 laparoscopic adjustable gastric banding operations (LAGB's) were performed by one surgeon. Our study examined the long-term complication rate.

Methods: All available medical notes (1079 patients) were reviewed.

Results: Mean weight was 120 kg, BMI 43.3. After 10 years of follow-up, complications occurred in 347 patients. 143 patients experienced band slippage; re-operation was required in half of these cases. 82 patients had their band removed due to complications, slippage in 60, erosion in 17 and band intolerance in 5. 136 patients experienced port problems; 37 were flipped on clinical or radiological fills, 17 patients had port infection. 50 ports required repositioning due to discomfort or difficulty with clinical fills; 16 were removed or replaced, including 5 for cutaneous erosion. 4 patients required other procedures to deal with intra-operative complications. 18 patients had a concurrent procedure. The only post-operative death was due to biliary peritonitis in a patient who had undergone simultaneous cholecystectomy.

Conclusion: Complication rates reflect the literature. Slippage rate may appear higher in our patients, but this is because most patients undergo radiological band fills hence many non-symptomatic slippages are detected. Only half of our slippages were clinically apparent or needed any intervention.

0138: POST-OPERATIVE RECOVERY FROM CHOLECYSTECTOMY AT A DISTRICT GENERAL HOSPITAL

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Laparoscopic cholecystectomy is one of the most common general surgical operations; however the majority of patients undergoing this procedure receive no routine surgical follow-up. Descriptions of the recovery period and quoted rates of potential complications when counselling patients for this procedure are hence potentially inaccurate.

We sent a postal questionnaire to all patients who had undergone a cholecystectomy at our institution over a 6 month period (median 5 months post-op) in order to investigate patients' recovery from this procedure.

60% of 100 patients contacted returned the questionnaire. Median time to return to work and driving was 2 weeks. 48% of patients reported having a post-operative problem that they consulted their GP or A&E regarding; 50% of these were prescribed antibiotics. Reported complications included LRTI in 3.5% of responders, and surgical site infection in 22%. A single patient required re-operation, and 6 patients (10%) reported re-admission to hospital.

Little information specific to our unit has previously been available to aid in counselling patients undergoing cholecystectomy. Rates of surgical site infection and post-operative antibiotic requirements were much higher than our estimates. Knowledge of this may have an impact upon the way in which we practice and perform this operation in the future.

0183: CENTRALISATION OF UPPER GI CANCER SERVICES – IS THE HUB BETTER THAN THE SPOKE?

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Aims: To assess whether patients diagnosed with oesophageal or gastric cancer at a local district general hospital (the "spoke") have a similar temporal pathway through the decision making and treatment process compared to those patients presenting at the centralised, tertiary hospital (the "hub").

Methods: Between April 2010 and April 2011, patients with a new diagnosis of oesophago-gastric cancer from both the hub and spoke hospitals were included. Data regarding diagnosis, time from diagnosis to multi-disciplinary (MDM) discussion and time from MDM decision to first treatment were all recorded and prospectively analysed.

Results: There was a statistically significant increase in the time from diagnosis to MDM discussion at the spoke hospital compared to the hub. (13.3 days vs.+ 25.67 days; P=0.001). However, time to first was significantly increased in the hub hospital compared to the spoke (43.4 days vs 25.5 days; P=0.023).

Conclusions: Withholding its limitations, this study is the first of its kind to show that there is a disparity in the management pathways of patients who first present to a regional hospital rather than the tertiary centre. Patients at the spoke hospital have a longer lead time into MDM but non-operative treatment appears to be delivered more quickly locally.

0203: OUTCOMES AT ONE YEAR FOLLOWING LAPAROSCOPIC SLEEVE GASTRECTOMY IN WALES

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Aim: Seven of the UK's ten worst areas for morbid obesity occur within Wales and bariatric surgery is the only proven treatment strategy. This study aimed to compare percentage excess weight loss (%EWL) and comorbidity resolution following laparoscopic sleeve gastrectomy (LSG) against UK National Bariatric Surgery Registry 2010 (NBSR) figures.

Methods: Retrospective analysis was performed on patients undergoing LSG at a single centre. Weight and Body Mass Indices (BMIs) were measured pre-operatively, at 3-6 months (n=28) and at 12 months (n=20). Obesity-related comorbidities of type-II diabetes mellitus (T2DM), hypertension and obstructive sleep apnoea (OSA) were recorded preoperatively and at 12 months.

Results: Twenty-eight patients (median age 45.5 years [17-63yrs], m:f=7:21) were studied. At 3-6 months median %EWL was 28.0% (9.2–67.2%); median BMI reduced from 46.5kgm⁻² to 37.8kgm⁻². At 12 months (20 patients), median %EWL was 55.7% (24.4–88.0%); median BMI reduced from 45.0kgm⁻² to 32.3kgm⁻². At 12 months, 100% of patients (7 pts) with T2DM, 100% (6 pts) with hypertension and 80% (5 pts) with OSA demonstrated improvement or complete resolution of comorbidity.

Conclusion: Percentage EWL and comorbidity resolution at twelve months compare favourably with those of the NBSR (%EWL=56% vs. 54%; T2DM resolution=100% vs. 50%) after LSG.

0231: A 10 YEAR RETROSPECTIVE ANALYSIS OF OUTCOMES FOLLOWING PERFORATED GASTRIC OR DUODENAL ULCER

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Aim: Despite improved medical management for peptic ulcer disease, incidence of perforated ulcer remains unchanged, resulting in high mortality and morbidity. This study aims to establish outcomes following surgery for perforated ulcer and identify factors predicting mortality and morbidity.

Method: Records of 48 patients undergoing surgery for perforated peptic ulcer from 2001 to 2010 were retrospectively reviewed. Factors significantly increasing mortality and morbidity were determined with multivariate logistic regression. Factors analysed included: age; ASA grade; pre-operative shock; co-morbidities and delayed presentation.

Results: There were 36 male and 12 female patients with mean age of 55 (range 20-89). 44 patients had a duodenal perforation. Only 2 perforations